Supreme Court, U.S.
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No. 91-1679

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

ILLINOIS COUNCIL ON LONG TERM CARE; GILMAN NURSING CENTER, an Illinois limited partnership; SPRING VALLEY NURSING CENTER, an Illinois limited partnership; and WOODSIDE MANOR, an Illinois corporation,

Petitioners,

v.

PHILLIP BRADLEY, in his official capacity as Director of the Illinois Department of Public Aid; DAWN CLARK NETSCH, in her official capacity as Comptroller of the State of Illinois; and PATRICK QUINN, in his official capacity as Treasurer of the State of Illinois,

Respondents.

Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether, in view of the consistent holdings of federal courts that States, in reimbursing providers for Medicaid services, may not freeze or diminish rates or delay implementation of rate increases for budgetary reasons, the Medicaid Act, and the Boren Amendment in particular, prohibit the State of Illinois, when it has failed to appropriate adequate funds to make the payments, from accomplishing the same result by delaying payments of the rates it has determined to be adequate and reasonable to the extent that annual payments to providers are reduced by one-sixth and providers are threatened with irreparable injury.

2. Whether, in view of the decision of this Court in *Wilder v. Virginia Hospital Association*, the fundamental obligation of the States under the Boren Amendment is to actually make payments for services that are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in rendering the services, and not just to determine rates that would, if paid, satisfy the statutory standard.

3. Whether a State's extraordinary delay in making Medicaid payments beyond its practice over more than ten years, to the extent that ten payments were made in a calendar year in lieu of the usual twelve payments, constitutes the kind of "change in payment methods and procedures" for which the State is required to make findings and assurances to the Secretary of the Department of Health and Human Services.

LIST OF PARTIES

The parties to this action both in the Federal District Court for the Northern District of Illinois and the Court of Appeals for the Seventh Circuit are those stated in the caption on the cover. Apparently by inadvertence, one of the petitioners was omitted from the decision of the Court of Appeals.

Pursuant to Supreme Court Rule 29.1, petitioners state that petitioner, Illinois Council on Long Term Care, is a not for profit corporation having no parent companies or subsidiaries, and petitioner, Woodside Manor, is a for profit corporation having no parent companies or subsidiaries.

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PETITION FOR WRIT OF CERTIORARI

Petitioners, Illinois Council on Long Term Care, Gilman Nursing Center, Spring Valley Nursing Center, and Woodside Manor, respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Seventh Circuit, entered in the above-entitled proceeding on February 18, 1992.

OPINIONS BELOW

The opinion of the Court of Appeals for the Seventh Circuit is reported at 1992 U.S. App. LEXIS 2074, and is reprinted in Appendix A, p. 1a, *infra.*

The opinion of the United States District Court for the Northern District of Illinois (Holderman, J.V.) granting the temporary restraining order has not been reported. It is reprinted in Appendix B, p. 11a, *infra.*

The opinion of the United States District Court for the Northern District of Illinois (Holderman, J.V.) denying the preliminary injunction is reported at 759 F.Supp. 1309, and is reprinted in Appendix C, p. 14a, *infra.*

JURISDICTION

Invoking federal jurisdiction under Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq.*, commonly known as the Medicaid Act, and under 42 U.S.C. §1983, petitioners brought this suit in the Northern District of Illinois on March 19, 1991 for injunctive and other relief. On March 29, 1991, the Northern District denied the petitioners' motion for preliminary injunction.

On petitioners' appeal, the Seventh Circuit on February 18, 1992, entered a judgment and an opinion affirming the Northern District's judgment and remanding with instructions to dismiss the case on the merits. No petition for rehearing was sought.

The jurisdiction of this Court to review the judgment of the Seventh Circuit is invoked under 28 U.S.C. §1254(1).

STATUTES AND REGULATIONS

42 U.S.C. §1396a(a)(13)(A)

A State plan for medical assistance must

(13) provide—

(A) for payment . . . of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality. . . .

42 CFR §447.45(d)

(d) Timely processing of claims. (1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.

(2) The agency must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt.

(3) The agency must pay 99 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities within 90 days of the date of receipt.

(4) The agency must pay all other claims within 12 months of the date of receipt. . . .

42 CFR §447.253(a)(b)

Other requirements:

(a) State assurances. In order to receive HCFA approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (g) of this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) Findings. Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings. . . .

STATEMENT OF THE CASE

I. THE MEDICAID ACT AND THE IDPA PAYMENTS

Illinois takes part in the federal-state Medicaid program and receives matching funds from the federal government in order to provide medical services for those people who qualify under 42 U.S.C. §1396 (the "Medicaid Act"). Pursuant to 42 U.S.C. §1396 and Ill. Rev. Stat. ch. 23, ¶¶1-1 *et seq.*, the Illinois Department of Public Aid ("IDPA") has developed a State Plan by which it administers the program. The Medicaid Act requires the State to submit its plan to the Secretary of the Department of Health and Human Services ("Secretary") and provide assurances that the plan provides for payment for Medicaid services by rates that are reasonable and adequate to meet the costs incurred by an efficiently and economically operated facility which provides care that conforms with applicable standards and laws.

Regulations issued by the Secretary require that a Medicaid agency must provide assurances and make findings that any change in its "payment methods and standards" conforms with the requirements of the Medicaid Act.

Member nursing homes of petitioner Illinois Council including the three named petitioners receive large percentages of their income from the IDPA. Since 1975, these homes have received monthly payments from the State between 30 and 45 days after the last date of services with only a few exceptional delays of not more than ten or fifteen days occurring near the end of the State's fiscal year.

During the State's fiscal year 1991 (July 1, 1990 to June 30, 1991), the time between the last day of services and payment of claims increased substantially. Facilities received payment for November, 1990 services between March 4 and March 14, 1991, 94 and 104 days after the last day of services, respectively. As of March 28, 1991, the date of the preliminary injunction hearing, the IDPA had not even sent requests for payment for December, 1990 services to the Comptroller.

Respondent Bradley admitted that the delay in payments was due to shortage of funds. The unrefuted evidence was that the delay in making payments would be increased by an additional ten days by the end of the fiscal year.

II. EFFECT ON PETITIONER NURSING HOMES

The evidence presented showed that because of the failure of the IDPA to make Medicaid payments, facilities were seriously behind in paying suppliers, utilities, mortgagees or lessors, and even the Internal Revenue Service. Owners and administrators were forced to spend consid-

erable time searching for financing, which detracted from the time they were able to devote to supervising quality of care. About half of the members of the Illinois Council had completely used up available credit. Most owners were financing their facilities by personal funds and borrowing. Owners were threatened with imminent failure to meet payroll and/or utility bills. Failure to meet payroll will result in the loss of professional staff.

At least one facility was no longer able to provide rehabilitative services for residents. Another was being threatened with removal of respirators. Nursing home residents were suffering a decline in quality of life: Specific examples include use of less satisfactory diapers and curtailment of food amenities. Residents were also suffering anxiety as to the continued viability of the places they had called home for many years. In short, the evidence demonstrated that the delay in making payments was putting in jeopardy the ability of the nursing homes to provide services conformable to the applicable standards and laws.

As of March 28, 1991, the IDPA had not assured nursing home operators that any further payments would be forthcoming in the near future. The Illinois Director of the Budget informed long term care providers in early March, 1991 that there would be a further delay of ten days in fiscal 1991.

III. DISTRICT COURT PROCEEDINGS

Petitioners filed their complaint for injunctive relief against respondent Bradley on March 19, 1991, and moved for a temporary restraining order the following day. Petitioners claimed that the delay in making payments constituted a violation of the Boren Amendment, and, addition-

ally, that the change in the timeliness of making payments constituted a change in the "payment methods and standards" for which the IDPA was required to receive the Secretary's approval.

On March 20, 1991, the district court, after reviewing petitioners' complaint, motion, and memorandum in support thereof, and hearing arguments presented by all parties, temporarily restrained respondent Bradley from delaying the processing of claims for provision of long-term care to Medicaid beneficiaries, and required him to pay all future claims not later than 30 days from the date of a claim's submission (Appendix B). The court specifically found that there was a reasonable likelihood that the delay of payment was equivalent to decreasing the payment rate and that it violated the Boren Amendment to the Medicaid Act (42 U.S.C. §1396a(a)(13)(A)). A hearing on petitioners' motion for preliminary injunction was set for March 29, 1991, and later moved up to March 28, 1991.

On March 25, 1991, petitioners filed an amended complaint, adding respondents Netsch and Quinn, and on March 27, 1991 petitioners filed a petition for rule to show cause why respondent Bradley should not be held in contempt of court for failure to take any action in response to the March 20, 1991 order of the district court.

On March 28, 1991, an evidentiary hearing was held in which petitioners presented evidence demonstrating the singular delay in the payment of rates and the irreparable injury it was causing to nursing homes in Illinois. Respondents presented no evidence.

On March 29, 1991, Judge Holderman entered a Memorandum Opinion and Order denying petitioners' motions for a rule to show cause and for preliminary injunction (Appendix C). Judge Holderman found that the approval

of the Illinois State Plan by the Secretary constituted a "finding that a delay in payments of up to twelve months" did not contravene the Medicaid Act. Moreover, Judge Holderman held that the Secretary consented to the risk sharing arrangement between IDPA and the Medicaid providers, whereby the Medicaid providers were "responsible for financing the first twelve months."

Judge Holderman further found that the reference to "payment methods and standards" in the regulations referred only to the establishment of rates, not to the timeliness of making payments. Since the IDPA had not changed the rates, he found that there was no change in the State Plan that needed the Secretary's approval.

IV. APPELLATE COURT PROCEEDINGS

On March 29, 1991, petitioners filed their notice of appeal with the district court, and on April 1, 1991 a motion for expedited appeal with the Court of Appeals for the Seventh Circuit. By order dated April 9, 1991, the motion was denied, a briefing schedule was set, and oral argument was scheduled for the week of June 10, 1991, and was heard on June 14, 1991.

On February 18, 1992, the appellate panel affirmed the decision of the district court and remanded with instructions to dismiss the case on the merits (Appendix A). The appellate panel based its decision not on the Secretary's alleged approval of the Illinois State Plan but on the language of the statute itself. It found that the Boren Amendment did not impose time limits on states for paying Medicaid claims (*Id.* at 5). However, on the question of whether the delay in payments constituted a change for which the Secretary's approval would be needed, the panel agreed with the district court that a change in "payment methods

and standards" referred only to changes in rates (*Id.* at 8-9). Hence, the panel decided that petitioners had no chance of success on the merits and ordered the district court to dismiss the case on the merits.

On March 6, 1992, petitioners filed a motion to stay the mandate pending the filing of this petition for certiorari, which motion was granted.

REASONS FOR GRANTING CERTIORARI

I.

THE RULING OF THE COURT OF APPEALS WILL PERMIT ALL STATES AND THEIR MEDICAID AGENCIES TO CIRCUMVENT THE CONSISTENT DECISIONS OF FEDERAL COURTS THAT HAVE CONSTRUED THE MEDICAID ACT TO ENJOIN REDUCTIONS IN REIMBURSEMENT SOLELY FOR BUDGETARY REASONS.

The appellate panel held that, under the Medicaid Act, Illinois could, solely for budgetary reasons, delay for up to twelve months making the payments it found would reasonably reimburse providers of Medicaid services, even though such delay threatened nursing homes (and, of necessity, their aged and infirm residents) with irreparable injury. By holding that the Boren Amendment requires only the establishment of reasonable rates but not timely payments in accordance therewith, the appellate panel placed itself in conflict with decisions of federal courts generally that have refused to permit States to reduce Medicaid reimbursement solely for budgetary reasons.

A. Federal Courts Have Consistently Held That a State May Not Reduce Medicaid Reimbursement Solely Because of Budgetary Concerns by Freezing, Diminishing or Delaying Implementation of Increases in Rates.

The intent of Congress in passing the Boren Amendment to the Medicaid Act, as confirmed consistently by the federal courts, is that reimbursement for services rendered under the Medicaid Act may not be diminished solely because of budgetary concerns. Congress clearly expressed this intention, stating: "The conferees would further note their intent that a state not develop rates . . . solely on the basis of budgetary appropriations." H. Conf. Rep. 1497, 96th Cong. 2d Sess. 154 (1980).

In accordance with this Congressional mandate, federal decisions have consistently held that a state may not freeze reimbursement rates, diminish rates or delay implementation of rate increases simply because of budgetary concerns. *See, Illinois Hospital Association v. Illinois Department of Public Aid*, 576 F. Supp. 360 (N.D. Ill. 1983); *Illinois Healthcare Association, Inc. v. Quern*, No. 77-C-1109, Medicare and Medicaid Guide (CCH) ¶32,396 (N.D. Ill. 1983); *Amisub (PSL), Inc. v. State of Colorado Department of Social Services*, 879 F.2d 789 (10th Cir. 1989), *cert. denied*, 110 S.Ct. 3212 (1990); *California Association of Health Care Facilities v. Department of Health Services*, No. S-90-1086, CCH Medicare and Medicaid Guide ¶39,053 (E.D. Cal. Oct. 1, 1990); *Kansas Health Care Association, Inc. v. Kansas Department of Social and Rehabilitation Services*, No. 90-4207-S, Medicare and Medicaid Guide (CCH) ¶39,059 (D. Kan. Dec. 31, 1990); *Temple University v. White*, 729 F. Supp. 1327 (E.D. Pa. 1990), *aff'd*, 941 F.2d 201 (3d Cir. 1991), *cert. denied, Snider v. Temple University*, 112 S.Ct. 873 (1992); *Washington State Hospital Association v. State of Washington*, No. C86-

463D, Medicare and Medicaid Guide (CCH) ¶36,352 (W.D. Wash. May 18, 1987); and *Nebraska Health Care Assoc. v. Dunning*, 578 F. Supp. 543 (D. Neb. 1983), *affirmed in part*, 778 F.2d 1291 (8th Cir. 1985) (as amended on denial of rehearing 1986), *cert. denied*, 479 U.S. 1063 (1987).

When the States of Colorado, Kansas and Nebraska attempted to cut, cap or freeze rates of reimbursement in order to reduce payments to meet budget constraints, the federal courts were quick to disallow such tactics as violative of the Medicaid Act's Boren Amendment, whether or not the Secretary of HHS had approved the rates. *See, Amisub (PSL), Inc. v. State of Colorado Department of Social Services, supra; Kansas Health Care Association, Inc. v. Kansas Department of Social and Rehabilitation Services, supra; Nebraska Health Care Association v. Dunning, supra.*

In the *California Association* case, *supra*, the court addressed a State's decision to implement rate increases on December 1, 1990 rather than on October 1, 1990, which would be the usual date of annual increases. The court found that "failing to *pay* legally mandated rates solely and exclusively because of budgetary concerns" (emphasis added) was illegal under the Medicaid Act, and ordered the State to refrain from "withholding and cause to be promptly disbursed" the payments established pursuant to the state plan. Hence the court held that delaying payment, not of the entire payment amount, but only of the increase, for two months would violate the Medicaid Act, if done solely for budgetary reasons.

B. The Decision of the Court of Appeals Permits a State Medicaid Agency to Diminish Medicaid Reimbursement Solely Because of Budgetary Concerns by Simply Delaying Payments Without Reducing the Rates.

Respondent Bradley denied that the IDPA establishes *rates*. He stated that the IDPA determines a methodology according to which "ultimate rates" and the consequent reimbursement payments are calculated.

Reimbursement to nursing homes for Medicaid recipients is made for monthly services. After the last day of each month of services, the IDPA, pursuant to the methodology, calculates a *per diem* rate and the total amount due the nursing home, and sends a Turnaround Invoice. The nursing home reviews and returns the Turnaround Invoice to the IDPA. The date on which such verified Turnaround Invoice is received by the IDPA constitutes the date of reception of the bill for services.

For purposes of the budget, the IDPA determines a projected average *per diem* rate for the fiscal year. This rate is then multiplied by the estimated number of Medicaid long term care patient days, and estimated third party payments are subtracted. The resulting number is submitted as part of the Illinois State budget for the fiscal year. Accordingly, in fiscal 1991, funding of the Medicaid payments to be made for long term care by the IDPA was based on 365 days, with payments to be made each month, that is twelve times during fiscal 1991, as in the past.

It is uncontroverted that historically these monthly payments had been made 30 to 45 days after the last date of service, but that by the date of the preliminary injunction hearing payments were being made 94 to 104 days after the last date of service, with a further delay of an

additional ten days expected before the end of the fiscal year. Hence, Illinois would make only ten payments in fiscal 1991, instead of the twelve on which the methodology was set and the Illinois budget was established.

The evidence shows that this delay made it impossible for many nursing homes to meet the costs incurred in providing services to Medicaid recipients. There was no showing that these homes, whose operators have operated nursing homes successfully for years, were anything other than economically and efficiently operated facilities. Moreover, in an attempt to meet costs, half of the Illinois Council members had completely exhausted available credit.

Respondent Bradley admitted that the delay in payments to nursing homes for services rendered to Medicaid recipients was due to a shortage of money on the part of the State. Therefore, solely for budgetary reasons, in fiscal 1991 Illinois reduced its Medicaid reimbursement below what it had determined was reasonable and adequate for nursing homes to meet the costs incurred in rendering services.

The delay in payment by IDPA caused a greater reduction in payments made to long term care providers than the rate changes and freezes invariably condemned and enjoined by the federal courts. Paying for only ten months in fiscal 1991 means that Illinois has reduced Medicaid reimbursement by one-sixth because of financial considerations. Illinois did not lower the rates; it simply did not make the monthly reimbursement payments. It is inconceivable that a state should be allowed to do directly what is clearly illegal when done indirectly. A state agency cannot hide the true nature of a rate decrease by "creative accounting," "sleight of hand," or placing "form over sub-

stance." *Illinois Healthcare Association, Inc. v. Quern*, No. 77-C-1109, Medicare and Medicaid Guide (CCH) ¶32,396 (N.D. Ill. 1983).

C. The Decision of the Court of Appeals Conflicts with This Court's Insistence on Compliance with the Medicaid Act in Practice and on the Prime Importance of Payment.

In *Wilder v. Virginia Hospital Assn.*, 496 U.S. 490, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990), this Court evidenced a concern lest the Boren Amendment be interpreted in such manner as to "render it a dead letter." 110 S.Ct. at 2520. Although the issue presented in *Wilder* was not that posed by petitioners in the instant matter, the reasoning of this Court appears to demand more than the mere setting of rates with an indefinite promise to pay that appears to satisfy the appellate panel.

In *Wilder*, this Court held that, under the Medicaid Act, a state plan must establish "a scheme for reimbursing" services, and styled as a state's "fundamental obligation" the payment of reasonable rates. *Id.* at 2513, 2520. As this Court held, "a State must reimburse providers according to rates" it has established, not merely set the rates. *Id.* at 2516. In passing the Boren Amendment, "Congress retained the ultimate requirement that the rates reimburse the 'reasonable cost' of the services provided." *Id.* at 2515. Moreover, this Court noted that the true issue is "noncompliance in practice," and cited 42 CFR §430.35 to indicate that "noncompliance in practice" may exist "regardless of whether the plan itself complies with" federal requirements. *Id.* at 2519.

Further, in refusing to hold that compliance with "bare procedural requirements" was the only right enforceable under §1983, this Court stated that such an interpretation would render "the entire reimbursement provision

essentially meaningless." *Id.* at 2519-2520. Citing legislative history, the Court pointed out that the flexibility given to the States by the Boren Amendment was "not intended to encourage arbitrary reductions *in payment* that would adversely affect the quality of care." *Id.* at 2520, citing S.Rep. No. 96-471, at 29 (emphasis added). Finally, this Court noted the intention of Congress that health care providers be able to sue in federal court for injunctive relief "to ensure *that they were reimbursed according to reasonable rates.*" *Id.* at 2521 (emphasis added).

This Court, therefore, has held that the Medicaid Act requires the making of payments that reasonably and adequately reimburse providers for services, not simply the setting of reasonable and adequate rates of reimbursement, which the States are then free to pay or not to pay regardless of the consequences for reimbursement in practice. Because the delay by the IDPA resulted in unreasonable and inadequate reimbursement, the decision of the appellate panel should be reversed.

II.

THE RULING OF THE COURT OF APPEALS IS CONTRARY TO SETTLED PRINCIPLES OF STATUTORY INTERPRETATION.

No one denies that the purpose of Congress in passing the Medicaid Act was to provide the needy aged and infirm with financial assistance that would insure appropriate medical care. Moreover, the Boren Amendment, as noted above, explicitly states that a state plan must provide for *payment.*

In devising legislation, Congress cannot foresee all problems that may later arise. When certain States reduced reimbursement by lowering or freezing rates, the federal

courts looked to the Congressional purpose and enjoined such reduction. When Illinois reduced reimbursement by delaying payments, however, the appellate panel deduced a contrary Congressional intent from an alleged failure of Congress to supplement the Secretary's regulations. Such statutory misinterpretation should not be allowed to stand.

A. The Court of Appeals Ignored the Explicit Language of the Medicaid Act and Other Evidence of the Intent of Congress.

1. *Statutory Language*: As this Court has frequently held, the first rule of statutory construction is to give effect to the "language and design of the statute as a whole." *Bethesda Hospital Association v. Bowen*, 485 U.S. 399, 405, 108 S.Ct. 1255, 1259, 99 L.Ed. 2d 460 (1988). However, to arrive at the design of the statute as a whole, it is necessary to consider the general purposes of Congress in devising the legislation. *Commissioner of Internal Revenue v. Engle*, 464 U.S. 206, 217, 104 S.Ct. 597, 604, 78 L.Ed. 2d 420, 429-30 (1984).

As this Court has made abundantly clear in its *Wilder* decision, the general purpose of Congress in devising the Medicaid Act was to provide the financial assistance necessary to furnish medical care to needy individuals. The Boren Amendment explicitly directs that a state plan provide for *payment*. To adopt an interpretation of the Medicaid Act that allows a state to avoid making payments reasonable and adequate for the provision of services to the needy is to subvert the purposes for which the statute was passed in the first place.

2. *Congressional Intent*: Congress explicitly directed that states were not to develop unreasonable and inadequate rates solely on the basis of budgetary appropriations.

It is a bizarre interpretation of Congressional intent to conclude that it is permissible to refrain from making reasonable and adequate payments solely on the basis of budgetary appropriations. Rates serve no purpose other than to enable the calculation of appropriate payments.

In passing the Omnibus Budget Reconciliation Act of 1987 ("OBRA 87"), Congress mandated a higher standard of care for nursing home residents. Mindful that "quality care is not free," the House Committee required an upward adjustment in rates, stating:

> It is the intent of the Committee that the States' Medicaid programs provide for an adjustment (in their Medicaid plan) and make payments commensurate to the cost incurred by the providers in implementing the new requirements and *that such payment be made as those costs are incurred.*

H. Rep. 100-391(I), 1987 U.S. Code Cong. & Ad. News, p. 2313-284; emphasis added. In stating that additional amounts be paid as costs are incurred, Congress evidently assumed that pre-OBRA 87 payments were being made as the costs were incurred.

3. *The COMC Case*: Respondents below relied on *Chicago Osteopathic Medical Centers v. Duffy*, 88 C 1174, Medicare & Medicaid Guide (CCH), ¶38,395 (N.D. Ill. 1989) ("*COMC*"), in which the IDPA's right to delay payments for Medicaid services for up to twelve months was recognized. As Petitioners pointed out, and the district court agreed, *COMC* is distinguishable from the instant case in that the services at issue in *COMC* were provided under a waiver of the provisions of the Boren Amendment.

More important, Congressional action since the decision in *COMC* unmistakably demonstrates that Congress intended the Boren Amendment to require prompt payment of claims. House Conference Report No. 101-964 (1990

U.S. Code Cong. & Ad. News, p. 2587) states that the House Bill would change the "Timely Payment" provision to extend the prompt payment requirements of 42 C.F.R. 447.45(d) to "any type of provider participating under a selective contracting waiver" (*Id.* at 2593). This provision of the House Bill was accepted by the conference agreement (*Id.* at 2598), and has been enacted into law, 42 U.S.C. §1396n(b)(4).

Thus, since *COMC*, Congress has enacted into law a provision that would grant a waiver of the Boren Amendment *only if 90% of claims are paid within 30 days and 99% within 90 days*. There can be no clearer proof that Congress intended the Boren Amendment to provide for timeliness of payments than its concern to subject to explicit prompt payment provisions any program for which a waiver of the Boren Amendment is to be granted.

In *COMC*, the Boren Amendment, requiring reimbursement by rates "reasonable and adequate" to meet the costs of an efficiently and economically operated facility, had been waived, and the court concluded that *in its absence* the only requirement was that payment be made within twelve months. Congress reacted by insisting that the 30/90 day rule be followed whenever the Boren Amendment is waived.

In the instant case, because the Boren Amendment has not been waived, it is clearly the Congressional intent that reasonable and adequate reimbursement be paid to enable efficiently and economically operated facilities to meet the costs incurred in providing quality care.

B. The Court of Appeals Purported to Ascertain Agency Intent Without Sufficient Evidence and then Unjustifiably Attributed Such Intent to Congress.

For the district court the decisive fact in denying the preliminary injunction was that the Secretary had approved the Illinois State Plan, which, for the payment of nursing home services, only sets an outside limit for payment of twelve months after the date of the receipt of the claim. From the simple fact of the Secretary's 1979 approval, the court concluded that the Secretary permits Illinois to take up to twelve months to pay nursing home invoices and approves the allocation of the first twelve months' of risk of nonpayment to the providers.

This conclusion will not withstand analysis. The Secretary's approval of the Illinois State Plan antedated the Boren Amendment. Thereafter, the Secretary's approval would be required only if there was a significant change in the "payment methods and standards" of reimbursement. It is undisputed that, with regard to the timeliness of payments, there was no significant change in the IDPA practice after the passage of the Boren Amendment until fiscal year 1991, as indicated above.

Moreover, as various federal courts have noted, the review of state plans by HCFA is cursory. *See, e.g., Amisub*, 879 F.2d, at 794. Indeed, as this Court has noted, one of the effects of the Boren Amendment was to curtail the review required of the Secretary. *Wilder*, 110 S.Ct. at 2516.

Finally, because the district court granted a Temporary Restraining Order fully aware of the provisions of the State Plan, the Secretary's regulations and the Boren Amendment, neither petitioners nor respondents presented any evidence of the position the Secretary had taken regarding the delay in payments by the IDPA. The district

court should not have based its ruling on a factual position not addressed by the parties without at least advising the parties that evidence was required on that issue.

This matter reached the appellate panel as an interlocutory appeal of the denial of a preliminary injunction. Petitioners pointed out the lack of evidence concerning the alleged intention of the Secretary, and requested at least the opportunity to present evidence on the issue should it be determinative of the outcome of the case.

The appellate panel converted an interlocutory ruling to a final decision on the merits by a slight but determinative shift of emphasis. It first noted that the Boren Amendment did not "impose time limits" on the States for paying Medicaid claims (Appendix A at 5). By grammatical analysis it concluded that under the Medicaid Act only rates, not payments, had to be reasonable and adequate to reimburse for services (*Id.* at 6).

The panel then noted that the Medicaid Act (1977) and Secretary's regulations (1979) contained some timely payment provisions, but none that set any time limit for nursing home reimbursement other than the twelve-month outside limit of the regulations (*Id.* at 6-7). Observing that Congress had taken no action in light of this absence, the panel concluded that the Medicaid Act permits a delay in reimbursement payments, regardless of the consequences, as long as the delay does not exceed twelve months (*Id.* at 7-8). Additionally, the panel decided that a change from the longstanding practice of making timely monthly payments did not constitute a change in "payment methods and standards," because that phrase is used in the regulations only to refer to the rates, not the payment of rates (*Id.* at 8-9).

This entire exercise in "statutory interpretation" is founded upon a dichotomy between "rates" and "pay-

ments," namely that the Medicaid Act and the Boren Amendment require only that rates be reasonable and adequate to reimburse for Medicaid services and not that reasonable and adequate reimbursement be actually made. The appellate panel obviously subscribes to such a dichotomy, but there is no evidence that either the Secretary or Congress share the panel's belief, which appears to contradict the analysis of the Medicaid Act of this Court in its *Wilder* decision.[1]

With regard to the Secretary, it is undisputed that the delay in payments was unprecedented and that timely monthly payments had been made in Illinois (with minor exceptions) since before the Boren Amendment. There is no record evidence of the Secretary's opinion as to whether the Boren Amendment requires payments more promptly than the outside limits set by his regulations.[2] Yet, without the benefit of any evidence, both the district court and the appellate panel concluded that the Secretary would have no objection to the delay in payments.

Worse, the appellate panel then deduced Congressional intent from the alleged failure of Congress to supplement the Medicaid Act by imposing the timely payment provisions that were not contained in the regulations. In fact, Congress did take action after the 1977 and 1979 timely

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[1] As noted above, according to respondent Bradley, the IDPA does not determine "rates" but a methodology, pursuant to which the "ultimate rates" for the monthly payments are calculated. Thus, the "rates" are determined only as a function of the payments that are actually made.

[2] As noted above, petitioners were unfairly precluded from presenting such evidence. Attached hereto as Appendix D is correspondence between HHS and IDPA that evidences HHS's disapproval of IDPA's delay in making payments, and also an admission by the IDPA that the delay was due to budgetary reasons.

payment provisions cited by the appellate panel, namely by adopting the Boren Amendment itself in 1980. The panel not only ignored the language and history of the Boren Amendment itself, as analyzed by this Court in *Wilder*, and the subsequent actions taken by Congress to insure prompt payment for Medicaid services, but imposed upon Congress the duty to foresee the delay in payment undertaken for budgetary reasons by Illinois and the dichotomy between "rates" and "payments" devised by the district court and the appellate panel.[3]

By unsubstantiated conjecture as to the intention of the Secretary and unwarranted attribution of this alleged intention to the Congress, the panel was able to reach a conclusion, the effect of which is to permit the reduction in Medicaid payments solely for budgetary reasons that all other federal courts have enjoined. At the very least, the appellate panel should have remanded the matter to the district court for the presentation of evidence as to the Secretary's understanding of the requirement for prompt payment under the Boren Amendment.[4]

---

[3] Respondents have not cited and petitioners have no knowledge of any federal decision prior to the instant lawsuit addressing the specific issue of a reduction in Medicaid reimbursement through delay in making payments rather than through a change in payment rates, although the *California Association* court (p. 11 above) held that a delay in paying increases violated the Medicaid Act. Subsequently, the United States District Court for the Northern District of New York, in *United Cerebral Palsy Assn. of New York State, Inc. v. Cuomo*, 1992 U.S. Dist. LEXIS 1122 (N.D.N.Y. 1992), in construing 42 C.F.R. §447.253, has explicitly followed the reasoning of the district court in the instant case, holding that delay in making payments did not constitute a change in "methods and standards" for which assurances had to be made to the Secretary.

[4] In responding to petitioners' "cynical argument" that the twelve-month delay can be further extended by IDPA's delaying the send-

(Footnote continued on following page)

More correctly, the panel should have refrained from foisting its own rates/payments dichotomy on Congress, and should have given effect to the plain language of the Boren Amendment when seen in light of the fundamental purpose of the Medicaid Act.

CONCLUSION

For all of the foregoing reasons, petitioners respectfully request this Court to grant this petition for certiorari, and to review and reverse the decision of the United States Court of Appeals of the Seventh Circuit in this matter.

Respectfully submitted,

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[4] *continued*
ing of the Turnaround Invoice in the first place, the appellate panel noted that there was "no evidence" that such delay had ever taken place (Appendix A at 7). There was, of course, only a preliminary injunction hearing held nine days after the original complaint was filed. By ordering the district court to dismiss the case on the merits, the appellate panel assured that such evidence would never be forthcoming.

APPENDICES

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APPENDIX A

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 91-1701

ILLINOIS COUNCIL ON LONG TERM CARE, GILMAN NURSING CENTER, an Illinois limited partnership, SPRING VALLEY NURSING CENTER, an Illinois limited partnership, et al.,

Plaintiffs-Appellants,

v.

PHILLIP BRADLEY, in his official capacity as Director of the Illinois Department of Public Aid, DAWN C. NETSCH, in her official capacity as Comptroller of the State of Illinois and PATRICK J. QUINN, in his official capacity as Treasurer of the State of Illinois,

Defendants-Appellees.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 91 C 1666—**James F. Holderman**, *Judge.*

ARGUED JUNE 14, 1991—DECIDED FEBRUARY 18, 1992

Before POSNER, MANION, and KANNE, *Circuit Judges.*

MANION, *Circuit Judge.* The Illinois Council on Long Term Health Care, an organization representing the interests of nursing homes in Illinois, and two of its member nursing homes sued various Illinois state officials for allegedly violating the Medicaid Act, 79 Stat. 343, as amended,

42 U.S.C. § 1396 *et seq.*, by delaying payments to nursing homes for services provided to poor residents. The plaintiffs moved in the district court for a preliminary injunction that would have ordered the defendants to reimburse the nursing homes more quickly. The district court denied the injunction. Because we find that the plaintiffs have no chance of success on the merits, we affirm and remand to the district court with instructions to dismiss the case.

I.

Congress enacted the Medicaid program to allow the federal government to provide financial assistance to states so that the states may provide medical assistance to poor people. State participation in the Medicaid program is voluntary. If a state does choose to participate and qualify for financial assistance it must, among other things, submit a "plan for medical assistance," describing the state Medicaid program's nature and scope, for the Secretary of Health and Human Services' approval. Among other things, the plan must establish a scheme to reimburse health care providers for the cost of medical services they provide to poor people. See generally *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510, 2513-14 (1990) (citing relevant statutory and regulatory provisions).

Illinois participates in the Medicaid program under a plan approved by the Secretary of HHS. In 1979, Illinois submitted, and the Secretary approved, a plan amendment stating that Illinois would meet "all requirements of 42 C.F.R. § 447.45 for timely payment of claims." Section 447.45(d) sets explicit time limits for paying claims to providers:

> (d) *Timely processing of claims.* (1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.
>
> (2) The agency must pay 90 percent of all clean claims from practitioners . . . within 30 days of the date of receipt.

> (3) The agency must pay 99 percent of all clean claims from practitioners . . . within 90 days of the date of receipt.
>
> (4) *The agency must pay all other claims [including those of nursing home operators]* within 12 months of the date of receipt.

42 C.F.R. § 447.45(d) (emphasis added). Subsections (d)(2) and (3) implement 42 U.S.C. § 1396a(a)(37)(A). That provision, enacted in 1977, sets forth in the statute the 30-day/90-day payment requirement for practitioners.

Billing for nursing home services under the Illinois Medicaid plan is accomplished by means of documents known as "Turnaround Invoices." Generally, after the last day of each month of services Illinois calculates the amount due a nursing home based on a per diem rate established for the fiscal year. Illinois then sends the nursing home a Turnaround Invoice reflecting this amount. The nursing home then makes what it considers to be appropriate adjustments on the Turnaround Invoice and returns it to the state. Illinois considers the nursing home's bill for services to be received when the nursing home returns the Turnaround Invoice.

Historically, Illinois has paid claims for nursing home services within 30 to 45 days after the last date of services, with a few slightly longer delays toward the end of several fiscal years. But because of budgetary problems in fiscal year 1991 (July 1, 1990 to June 30, 1991), the state consistently began to delay payments. For example, the state did not make payments for November 1990 services until between 94 and 104 days after the last day of services.

Nursing home operators say they were able to live with payments 30 to 45 days from the last day of services. However, they insist that the recent delays in payments from Illinois have caused them to fall behind in paying their own bills. Faced with a situation that they allege jeopardizes their very existence (an allegation the defendants dispute), the plaintiffs in this case (two nursing homes

and an umbrella organization representing nursing homes) sought an injunction from the district court that would require Illinois' officials to pay claims for nursing home services within 45 days of the last date of services included in the claim. The district court denied the plaintiffs' request for a preliminary injunction, holding that the plaintiffs' likelihood of success on the merits was negligible. The plaintiffs filed a timely interlocutory appeal under 28 U.S.C. § 1292(b) from the district court's decision.

II.

To be entitled to a preliminary injunction, a plaintiff must demonstrate some likelihood of success on the merits. If a plaintiff seeking a preliminary injunction cannot show that his chance of prevailing on the merits is "better than negligible," a court must deny the injunction regardless of how heavily any other equities may weigh in the plaintiff's favor. *Centurion Reinsurance Co., Ltd. v. Singer*, 810 F.2d 140, 145 (7th Cir. 1987); see also *Curtis v. Thompson*, 840 F.2d 1291, 1296 (7th Cir. 1988). The district court properly decided to deny the plaintiffs' request for a preliminary injunction because the plaintiffs have failed to demonstrate a chance of success on the merits.

The plaintiffs argue that the recent delay in payments by Illinois violates both the Medicaid Act and the Secretary's regulations. The plaintiffs first argue that the delayed payments violate the Boren Amendment to the Medicaid Act, Pub. L. 96-499, § 962(a), 94 Stat. 2650, codified as amended at 42 U.S.C. § 1396a(a)(13)(A). The Boren Amendment provides that

> a State plan for medical assistance must
>
> provide . . . for payment . . . of [health care services] provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, *are reasonable and adequate to meet the costs which*

> *must be incurred by efficiently and economically operated facilities in order to provide health care services in conformity with applicable State and Federal laws . . . .*

(Emphasis added.) The Boren Amendment does not on its face impose any time limits on states for paying claims but the plaintiffs insist that it requires states to make timely payments. Stripped of embellishments, their argument proceeds like this: The Boren Amendment requires that payments be adequate to enable providers to meet the costs required to render sufficient health care services. Untimely payments can be inadequate payments since providers need the money in time to meet their own expenses, such as payroll, mortgages, and utilities. If the financial pressure caused by the late payments becomes severe (as sources of credit dry up and creditors insist on payment), care to residents may suffer to the point that it becomes inadequate (or, in the worst case, less accessible as providers go out of business). The plaintiffs insist that since late payment can be inadequate payment, resulting in inadequate care, untimely payment of claims can violate the Boren Amendment and a court must order state officials to speed up their payments to cure the violation.

As a practical matter, it does make sense to consider the timeliness of payments as an element of their adequacy. A dollar one or two months from today is not the same as a dollar today. Money has a time value, and businesses need money to pay their bills when due, not one or two months later. But the question is not what reimbursement scheme might make sense but whether the Boren Amendment requires timely payment—in other words, whether the Boren Amendment imposes time limits on the states for paying Medicaid claims. Based on the amendment's language and the context of the statutory and regulatory scheme in which it appears, we conclude it does not.

Although timeliness of payments could logically be an element of their adequacy, the Boren Amendment's lan-

guage and context demonstrates that is not the approach Congress took. As we have noted, the Boren Amendment does not on its face impose any time limits or refer directly to timeliness in any way. Moreover, the Boren Amendment's language requires rates, not actual payments, to be reasonable and adequate. The words "reasonable and adequate" modify the noun "rates," not "payment." See 42 U.S.C. § 1396a(a)(13)(A) (state plan must provide "for payment . . . through the use of rates . . . which the state finds . . . are reasonable and adequate . . ."). It may be true that the reason for requiring adequate rates is to assure adequate payment for services. But "rate" means an amount, not the time at which that amount must be paid. The logical conclusion from this is that the Boren Amendment focuses on the amount of a state's payments, not the time in which the state makes those payments.

The statutory and regulatory context in which the Boren Amendment appears reinforces this conclusion. "[A] statute is to be read as a whole, since the meaning of statutory language, plain or not, depends on context." *King v. St. Vincent's Hospital*, 112 S. Ct. 570, 574 (1991). At the time Congress passed the Boren Amendment, both the Medicaid Act and its implementing regulations expressly addressed the time in which states must pay claims. The Act, in 42 U.S.C. § 1396a(a)(37)(A), enacted in 1977 (see Pub. L. 95-142, § 2(b)(1)(C), 91 Stat. 1176 (1977)), requires that a state plan provide claim payment procedures to ensure that "90 per centum of claims [from health care practitioners] . . . are paid within 30 days of the date of receipt . . . and that 99 per centum of such claims are paid within 90 days of the date of receipt . . . ." The regulation, 42 C.F.R. § 447.45(d), promulgated in 1979, pursuant to the express authority granted by 42 U.S.C. § 1302 to promulgate regulations to administer the Medicaid Act (see 44 Fed. Reg. 30344 (May 25, 1979)), adopts the 30-day/90-day rule for practitioners' claims and requires that states "pay all other claims within 12 months of the date of receipt . . . ." 42 C.F.R. § 447.45(d)(2),(3), and (4).

Section 1396a(a)(37)(A) shows that when Congress wanted to impose time limits for the payment of certain Medicaid claims, it did so explicitly. Moreover, given the express time limits previously imposed by § 1396a(a)(37)(A) and 42 C.F.R. § 447.45(d), it is all the more unlikely that Congress intended to impose further time limits through the Boren Amendment, which does not mention time at all and speaks only about payment rates. We conclude from the Boren Amendment's language and context that the Boren Amendment does not address the timeliness of claim payment. Cf. *King*, 112 S. Ct. at 573-74. A state complies with federal law so long as it pays providers' claims within the express time limits established by the statute and regulations (in this case, the 12-month limit for "all other claims" set forth in 42 C.F.R. § 447.45(d)(4)).

The plaintiffs insist that if the only time limit placed on Illinois is § 447.45(d)(4)'s 12-month limit, the state can avoid paying its Medicaid bills forever. This is so, say the plaintiffs, because the 12-month period begins when the state receives the provider's claim. However, the provider cannot submit its claim until it receives a Turnaround Invoice, a document the state generates; as we have noted, Illinois deems receipt of the Turnaround Invoice to be receipt of the claim. The plaintiffs assert that Illinois may avoid paying claims simply by not sending the Turnaround Invoice. Illinois will never receive a claim, so the 12-month time limit for payment will never begin. According to the plaintiffs, Congress could not have intended this result.

There are at least three responses to this cynical argument. First, there is no evidence that Illinois has ever delayed or will ever delay sending Turnaround Invoices to avoid paying claims. Indeed, there is no evidence that Illinois is not paying claims; it is just taking longer to pay them than it has in the past. Second, the plaintiffs' argument ignores 42 C.F.R. § 447.45(d)(1), which requires the state "to require providers to submit all claims no later than 12 months from the date of service." If Illinois did delay sending Turnaround Invoices so that the nursing

homes could not submit their bills within 12 months from the date of service, it would violate § 447.45(d)(1). Third, the plaintiffs' scenario does not change the Boren Amendment's language and context, both of which indicate that the Boren Amendment does not address timeliness. If the plaintiffs want absolute assurance in the Medicaid Act that the scenario they posit never comes to pass, they should look to Congress to amend the Medicaid Act to prevent it.

Besides arguing that Illinois has violated the Boren Amendment by delaying payments, the plaintiffs also argue that Illinois has violated 42 C.F.R. §§ 447.253(a) and (b). Section 447.253(a) provides that whenever a state seeks to change the "payment methods and standards" in its plan, it must make the findings and assurances set forth in §§ 447.255(b) through (g). Section 447.253(b) requires that whenever a state makes a change in its "methods and standards," it must make certain findings. The plaintiffs argue that by making payments later than it historically had made them, Illinois changed its "methods and standards"; since Illinois did not make the necessary findings and assurances before slowing down its payments, it violated §§ 447.253(a) and (b).

Sections 447.253(a) and (b) do not apply to Illinois' decision to delay payments to nursing homes. Section 447.253, read as a whole and in the context of accompanying regulations, addresses methods and standards for rate setting and not the time in which payments must be made. Section 447.253 appears in a part of Subpart C of Chapter IV of 42 C.F.R. entitled "Payment Rates." Section 447.252(b) states that a plan must "specify comprehensively the methods and standards used by the agency to set payment rates." The findings mandated by § 447.253(b) (the section relevant to nursing homes), and the assurances mandated by §§ 447.253(c), (f), and (g), all relate to methods and standards for determining payment rates. None of the findings or assurances that §§ 447.253(b) through (g) require mentions anything about assuring that states will make timely payments. Since a specific regulation,

42 C.F.R. § 447.45(d), imposes express time limits for payments to Medicaid providers, it is unlikely that the Secretary would implicitly address timeliness in a separate regulation that does not mention timeliness.

Moreover, Subpart C of Chapter IV of 42 C.F.R., the subpart containing § 447.252 and § 447.253, implements the Boren Amendment. See 42 C.F.R. § 447.250(a). As we have seen, the Boren Amendment does not address the timeliness of payments. It follows that the regulations implementing the Boren Amendment would not address timeliness either. The language of the regulations, which expressly addresses rate-setting but not timeliness, is consistent with this conclusion. Since a delay in making payments is not the kind of "change in payment methods and procedures" that 42 C.F.R. §§ 447.252 and 447.253 address, Illinois did not have to make the findings and assurances those sections require when it increased the time in which it paid the plaintiffs for their services.

The district court correctly determined that the plaintiffs were not entitled to a preliminary injunction because they could not show a better than negligible chance of succeeding on the merits of their claims. In fact, the plaintiffs have not demonstrated any chance of success on the merits. The plaintiffs' claims depend on alleged violations of the Boren Amendment and its regulations. But Illinois has not violated either the Boren Amendment or its implementing regulations because neither the Boren Amendment nor the regulations address Illinois' conduct—delaying payments to Medicaid providers. The only limit on the time in which Illinois must pay the plaintiffs' Medicaid claims is the 12-month rule set out in 42 C.F.R. § 447.45(d)(4). The plaintiffs may wish to be paid more quickly, and perhaps the law should require more timely payments. But that decision is for Congress, not the federal courts, to make.

The plaintiffs have not ever suggested that Illinois has violated § 447.45(d)(4) or that any real possibility exists that it will do so in the future. Since plaintiffs cannot win

on the merits, there is no point in remanding the case for further proceedings. Therefore, we affirm the district court's judgment and remand with instructions to dismiss the case on the merits. See *Pratte v. N.L.R.B.*, 683 F.2d 1038, 1044 (7th Cir. 1982); *Hurwitz v. Directors Guild of America*, 364 F.2d 67, 70 (2d Cir. 1966).

AFFIRMED AND REMANDED WITH INSTRUCTIONS TO DISMISS.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

APPENDIX B

[Dated March 20, 1991]

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

ILLINOIS COUNCIL ON LONG TERM CARE; GILMAN NURSING CENTER, an Illinois limited partnership; SPRING VALLEY NURSING CENTER, an Illinois limited partnership; and WOODSIDE MANOR, an Illinois corporation, Plaintiffs,	)	
v.	)	NO. 91 C 1666
PHILLIP BRADLEY, in his official capacity as Director of the Illinois Department of Public Aid, Defendant.	)	

ORDER

JAMES F. HOLDERMAN, District Judge:

Illinois Council On Long Term Care, Gilman Nursing Center, Spring Valley Nursing Center and Woodside Manor, having moved for a Temporary Restraining Order pursuant to Rule 65 of the Federal Rules of Civil Procedure, notice thereof having been provided to counsel for the Defendant Phillip C. Bradley, Director of the Illinois Department of Public Aid, and the court having considered this motion, the Complaint in this action, Plaintiffs'

Memorandum of Law in Support of Plaintiffs' Motion for Issuance of a Temporary Restraining Order and the exhibits attached to all of these documents and having heard the arguments of counsel, and based on the court's findings that:

(a) The standard to be applied, as has been set forth by the United State Court of Appeals for the Seventh Circuit, is whether plaintiffs have demonstrated a better than negligible likelihood of prevailing on the merits of this action; whether plaintiffs will suffer irreparable harm from which there is no adequate remedy at law; whether issuance of the temporary restraining order will not disserve the public interest; whether the threatened injury to plaintiffs outweigh any threatened harm the temporary restraining order may provide to defendants;

(b) The State admittedly has delayed and unless enjoined will continue to delay the payment of funds, contrary to the procedures and the timeliness that has been heretofore used in conjunction with these payments;

(c) There is a reasonable likelihood that the delay of payment is equivalent to decreasing the payment rate;

(d) There is a reasonable likelihood that the delay of payment is in violation of 42 U.S.C. §1396a (a)(13)A;

(e) The recent case of *Chicago Osteopathic Medical Center vs. Duffy*, 1989 U.S. Dist. LEXIS 12824, is distinguishable from this matter in that the situation there was not one where there was a possibility of harm resulting such as the harm that has been shown by the affidavits to potentially occur

here, and there is no waiver of the Boren Amendment or negotiated rates in this matter;

(f) There has been a showing by plaintiffs of substantial harm if this temporary restraining order is not entered and no indication with regard to harm to be suffered by the State if plaintiffs' request for this temporary restraining order were to be granted;

(g) The temporary restraining order will not disserve the public interest.

IT IS HEREBY ORDERED that the Defendant is temporarily restrained pending a hearing on plaintiffs' request for preliminary injunction from delaying the processing of claims for provision of long-term care to Medicaid beneficiaries, and shall be required to pay all such claims within the same time frame that has been utilized heretofore but in any event not to be later than 30 days from the date of submission of such claims.

IT IS FURTHER ORDERED this case shall be set for a hearing on entry of a preliminary injunction on March 29, 1991 at 10:30 a.m. and the parties shall proceed with expedited discovery to prepare for said hearing.

IT IS FURTHER ORDERED THAT no bond shall be required with respect to this Order.

Issued this 20th day of March, 1991 at 1:45 p.m.

ENTER:

JAMES F. HOLDERMAN
United States District Judge

APPENDIX C

[Dated March 29, 1991]

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

ILLINOIS COUNCIL ON LONG TERM CARE; GILMAN NURSING CENTER, an Illinois limited partnership; SPRING VALLEY NURSING CENTER, an Illinois limited partnership; and WOODSIDE MANOR, an Illinois corporation, Plaintiffs,	)	
v.	)	NO. 91 C 1666
PHILLIP BRADLEY, in his official capacity as Director of the Illinois Department of Public Aid; DAWN CLARK NETSCH, in her official capacity as Comptroller of the State of Illinois; and PATRICK QUINN, in his official capacity as Treasurer of the State of Illinois, Defendants.	)	

MEMORANDUM OPINION AND ORDER

JAMES F. HOLDERMAN, District Judge:

Plaintiffs, Illinois Council on Long Term Care (a not-for-profit health care association representing over 150 proprietary Illinois nursing homes) and three nursing

homes with at least 70% Medicaid recipients as residents, bring this action for declaratory and injunctive relief against the director of the Illinois Department of Public Aid (IDPA), the state agency which administers the Illinois Medicaid program, and the Comptroller and Treasurer of the State of Illinois.

Plaintiffs seeks preliminary injunctive relief claiming that the slowdown in IDPA's Medicaid reimbursements to nursing homes for care provided to Medicaid beneficiaries violates the federal Medicaid Act (the "Act"), Title 42, United States Code, Sections 1396a(a)(2), 1396a(a)(13)(A), and 1396a(a)(30)(A), and implementing regulations at 42 C.F.R. § 447.250-.257.

BACKGROUND FACTS

Illinois participates in the Medicaid program, a cooperative federal-state program established by the Act under which federal matching funds are provided to states to furnish medical assistance to persons "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396. IDPA administers and supervises the Illinois Medicaid program pursuant to § 1396a(a)(5) and Ill. Rev. Stat. ch. 23, § 1-1 *et seq.* Plaintiff Illinois Council on Long Term Care has a membership comprised of 150 proprietary Illinois nursing homes. Most of the Council's members, including the three plaintiff nursing homes, participate in the Illinois Medicaid program.

Under 42 U.S.C. § 1396a, a state becomes eligible to participate in the Medicaid program, and to receive federal matching funds, by submitting to the Secretary of Health and Human Services (HHS) (the "Secretary") a State Medicaid Plan that meets the federal standards prescribed in

the Act and its implementing regulations, and by having the plan approved by the Secretary. A state plan for medical assistance must provide for financial participation by the state on a basis "which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan." 42 U.S.C. § 1396a(a)(2).

As of October 1, 1981, the Act requires a state plan to provide for payment at rates "which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. . . ." 42 U.S.C. § 1396a(a)(13)(A).

Section 1396a(a)(30) requires that state plans "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care."

A Medicaid agency must pay for long term care services using rates determined in accordance with methods and standards specified in an approved state plan. 42 CFR §447.253(g).

When a Medicaid agency makes a change in its "payment methods and standards," but not less often than annually, the agency must provide assurance and make findings that "the agency pays for . . . long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal

laws, regulations, and quality and safety standards." 42 C.F.R. § 447.253(a), (b).

The IDPA has established monthly billing cycles. Historically, IDPA has had a median delay of approximately 30 days from the time services are rendered to the commencement of the processing of claims, and another 30 days delay before reimbursement is made to the providers. Plaintiffs claim that this 60 day delay in reimbursement from the date services are provided reflects the intention of the state plan and the expectations of the nursing homes. In fiscal years 1989 and 1990, however, the delay after presentation of claims to IDPA increased from 30 days to approximately 40 days. The delays expanded again in fiscal 1991. Payment for November, 1990 services were made between 80 and 90 days after presentation of the invoice, and, on March 21, 1991, payment was received for certain services rendered through December 6, 1990. As of the date of this opinion, March 29, 1991, no payments had been received by any nursing homes for any services rendered after December 6, 1990.

DISCUSSION

To support the issuance of a preliminary injunction, a plaintiff must demonstrate: (1) a reasonable likelihood of success on the merits; (2) the inadequacy of a remedy at law; (3) the existence of irreparable harm without the injunction; (4) that the threat of harm to the plaintiff outweighs any harm to the defendant if the injunction were issued; (5) that the public interest would not be disserved if the injunction were granted. *Kellas v. Lane*, No. 89 C 4290. slip op. at 3 (7th Cir. Jan. 22, 1991). Though the plaintiff must satisfy each of these elements to prevail, his threshold burden is to show the first three

factors. *Id.* Only when this burden is met does the inquiry become a "sliding scale" analysis of the harm to the parties and the public from the grant or denial of the injunction and the actual likelihood of success on the merits. *Id.*

In order to establish a reasonable likelihood of success on the merits, the plaintiff need only show that his chances are better than negligible. *Id.* The court, having considered the evidence presented at the evidentiary hearing held on March 28, 1991, finds that plaintiffs have not met this standard.

Plaintiffs allege that the delay of Medicaid reimbursement payments violate various provisions of 42 U.S.C. § 1396a(a)—namely §§ 1396a(a)(13)(A), 1396a(a)(30)(A), and 1396a(a)(2). The provisions of § 1396a(a) set forth the requirements of state plans for medical assistance. The Secretary will approve state plans which fulfill the conditions specified in § 1396a(a). 42 U.S.C. § 1396a(b). It is undisputed that the Illinois State Medicaid Plan (the "State Plan") has been approved by the Secretary. The only provision in the State Plan concerning timeliness of payments for services rendered by providers is § 4.19(e). It states that "[t]he Medicaid agency [IDPA] meets all requirements of 42 CFR 447.45 for timely payment of claims." (Exhibit E, Illinois State Medicaid Plan, p. 61.) That federal regulation requires IDPA to pay all claims within twelve months of the date of receipt of the claim. 42 C.F.R. § 447.45(d)(4).

In evaluating the State Plan pursuant to 42 U.S.C. § 1396a(b), the Secretary was required to evaluate the State Plan in light of the requirements of 42 U.S.C. § 1396a(a). The subsequent approval of the State Plan signifies the Secretary's finding that the sole timeliness

provision in § 4.19(e) adequately addresses any timeliness concerns raised by § 1396a(a). For example, the Secretary's approval of the State Plan demonstrates that the directive of 42 U.S.C. § 1396a(a)(13)(A)—that the plan provide for payments through the use of rates which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities—is satisfied by the State Plan. Also, approval indicates that the Secretary found that the State Plan, including the § 4.19(e) timeliness provision, adequately "provide[s] such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care," as required by § 1396a(a)(30)(A). Finally, the Secretary's approval demonstrates that the State Plan provides for financial participation by the state on a basis "which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan," as required by 42 U.S.C. § 1396(a)(2).[1] Thus, by giving its imprimatur to the State Plan, the Secretary has made a finding that a delay in payments of up to twelve months, as permitted by the State Plan, does not contravene the provisions of § 1396a(a). *See Wisconsin Hospital Ass'n v. Reivitz*, 733 F.2d 1226, 1237 (7th Cir. 1984) (determination by Secretary of the reasonableness and adequacy of rates provides major guidance to the dis-

[1] Defendants claims that § 1396a(a)(2) does not apply to Illinois since the Illinois Medicaid program is administered on a state basis, and not a county basis. Thus, "the lack of adequate funds from local sources" is not relevant to the Illinois Plan. The court need not address this issue since the court finds that, in any event, defendants have not violated § 1396a(a)(2).

trict court). By approving the State Plan, the Secretary consented to the manner in which the State of Illinois and the Medicaid providers in Illinois are to share the risk of nontimely payment, with the Illinois providers responsible for financing the first twelve months and the State of Illinois responsible for any delays thereafter.

As stated above, it is the State Plan which must comply with 42 U.S.C. § 1396a(a), and not the "practices," "intentions," or "expectations" of the agency and the providers.[2] Plaintiffs' allegations of a slowdown simply constitute a change in practice by IDPA. A new practice, even one that imposes great hardships on Medicaid providers, that does not violate the provisions of the State Plan cannot, by itself, cause the Plan to contravene the federal requirements with which the Plan has been found to comply.

Plaintiffs contend that, by paying in a slower manner than was previously the practice of IDPA, the agency has violated 42 C.F.R. § 447.253(b)(1)(i).

An agency does not encounter the requirements of 42 C.F.R. § 447.253(a) and (b) unless a change has been made to the state plan's "methods and standards." Throughout this subpart of the federal regulations, the term "methods and standards" relates to payment rates. *See* 42 C.F.R. § 447.252(b) ("the methods and standards used by the agency to set payment rates"); § 447.253(f) ("significant

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[2] Plaintiffs argue that "[m]onthly payment of Medicaid reimbursement rates . . . has been the consistent *practice* of the IDPA under its state plan," and "it is clear that the *intention* of the State and the *expectation* of the nursing homes is that the monthly bills will be paid on a regular basis, not to exceed sixty days from median date services are provided. . . ." (Mem. in Support, p. 3., emphasis added)

changes to its methods or standards for setting payment rates"); § 447.253(g) ("using rates determined in accordance with methods and standards specified in an approved State plan"). The provision of the Medicaid Act implemented by this subpart, 42 U.S.C. § 1396a(a)(13)(A), requires "the use of rates (determined in accordance with methods and standards developed by the State)." Thus, unless the IDPA slowdown amounts to a change in the "methods and standards" of payment rates, IDPA is not required to make the assurances and findings specified in 42 C.F.R. § 447.253(a) and (b).

Plaintiffs equate delayed payments with reduced payments, which would constitute a change of rates under the State Plan. However, plaintiffs cite no authority for this position. Most of the cases cited by plaintiff pertain to actual rate changes. The remainder involve rate freezes. None of the cases concern delays in reimbursement without alleging that the actual payment rates used by the state agency are different from those set out in the state plan. Plaintiffs make two arguments to equate the slowdown to a rate reduction. First, plaintiffs claim that the slowdown is tantamount to a decision by the IDPA to make no payments for November and half of December, 1990. Second, plaintiffs try to equate the slowdown to a rate reduction of 12.5 percent for 1990. Both of these positions would be correct if IDPA had taken the posture that no reimbursement for services rendered during that one and one half month period would be forthcoming. However, the circumstances are to the contrary. IDPA has not denied liability for that period, and has stated that it plans to reimburse plaintiffs for that period at the rates and in the time frame set forth by the State Plan. At this point, plaintiffs are unable to, and have no reason to, disprove this assertion. Thus, plaintiffs attempts to

equate delayed payment with reduced payment are unpersuasive.

The court finds that the payment slowdown is not inconsistent with the terms of the State Plan. Consequently, the slowdown does not constitute an amendment to the Plan and IDPA is not required to obtain an approval from the Secretary through the submission of assurances and findings.[3]

For these reasons, the court finds that plaintiffs do not have a better than negligible likelihood of success on the merits of their claim. Where the plaintiff is unable to show likelihood of success on the merits, the harm to the plaintiff will never override this failure. *Curtis v. Thompson*, 840 F.2d 1291, 1296 (7th Cir. 1988). Denial of an injunction for failure to establish such likelihood of success is appropriate and proper. *Id.* at 1297.

Although the court need not and therefore will not address the other requirements for the issuance of a preliminary injunction, the court is not unmindful of the necessity of adequate health care for those who qualify for Medicaid benefits and would once again encourage the parties to attempt to settle this dispute.

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[3] The methods and standards for establishing payment rates as set forth in the State Plan include a two month working capital component. (Exhibit E, Illinois State Medicaid Plan, Attachment 4.19-D, p. 12E.) Plaintiffs contend that the working capital component infers that reimbursements by IDPA must be made within sixty days of the date services are rendered in order for Medicaid providers to maintain proper working capital. The court disagrees. The working capital level provided in this section of the State Plan is for the purposes of calculating the capital cost component in establishing payment rates. A plain reading of this section in context does not persuade the court that the working capital component constitutes an indirect requirement that IDPA pay Medicaid claims within sixty days.

CONCLUSION

Defendants' motion to dissolve the temporary restraining order dated March 20, 1991 is GRANTED. Plaintiffs' motion for a rule to show cause and motion for preliminary injunction are DENIED. The parties are encouraged to discuss settlement and report on the status thereof on May 3, 1991 at 10:00 a.m.

ENTER:

JAMES F. HOLDERMAN
United States District Judge

DATED: March 29, 1991

APPENDIX D

[DEPARTMENT OF HEALTH & HUMAN SERVICES LETTERHEAD]

Region V
105 West Adams
Chicago, Ill 60603

Philip C. Bradley, Director
Illinois Department of Public Aid
Jesse B. Harris Building
100 South Grand Avenue East
Springfield, Illinois 62762-0001

Dear Mr. Bradley:

This letter is to express my serious concern about the length of time the Illinois Department of Public Aid (IDPA) is taking to pay providers under the Illinois Medicaid program. My office has been receiving inquiries and concerns from Medicaid providers, the press and the Congress. It appears that the concerns are now intensifying despite previous State optimism that backlogs would be reduced during the State's current fiscal year.

The State's figures on the average number of days to pay claims from Medicaid providers has consistently exceeded 30 days for calendar years 1989 and 1990 and approached or exceeded 50 days in July of each of those years. Average number of days to pay most claims exceeded 50 days in December of 1990 and have risen fairly steadily since then.

I had hoped that the increased appropriations for the current State fiscal year would be used to reduce the backlog

of claims. The average number of days from claim receipt to payment for August and September, 1991, however, are the highest overall since early 1989. The most recent figures we have indicate that average payment days for non-institutional provider, pharmacist, ambulatory hospital, and physician claims are well in excess of 100 days, long term care claims are in excess of 90 days and inpatient hospital claims are in excess of 80 days.

I am especially concerned about providers who serve a large percentage of Medicaid and uninsured patients that are highly dependent on Medicaid reimbursement for a significant portion of their revenues. I understand that IDPA has been prioritizing payments on the basis of the percentage of Medicaid recipients a provider serves. This, however, is not solving the basic underfunding problem.

As we discussed when I spoke with you recently, I would like to meet with you to discuss your plan of action for addressing this serious issue. In addition, I would like to discuss my concerns related to the recently submitted request to revise Illinois' alternative disposition plan for the mentally ill and mentally retarded residents of nursing facilities. I am requesting that you invite representatives of the Illinois Department of Mental Health and Developmental Disabilities as well as a representative of the Governor's office to this meeting.

My office will be in contact with you to arrange a convenient time for this meeting.

Sincerely,

Chester C. Stroyny
Regional Administrator

cc: [Various]
file code—R-4, Illinois disc 10—LATEPAYM.LT2

Mr. Phil Bradley
Director
Department of Public Aid
Jesse B. Harris Building II
3rd Floor
100 S. Grand Avenue, East
Springfield, Illinois 62762

Dear Mr. Bradley:

During fiscal year (FY) 1991, staff from the Chicago Regional Office (RO) of the Health Care Financing Administration (HCFA) conducted an operational review of your Medicaid Management Information System (MMIS). The purpose of the review was to evaluate your State's system against performance standards and review criteria established under the authority of section 1903(r) of the Social Security Act. A copy of the System Performance Review (SPR) package used for the MMIS evaluation was furnished to you prior to the last quarter of FY 1990 to permit you to prepare for the review.

The SPR results of FY 1991 indicate that your State's MMIS meets all current conditions for reapproval. Consequently, the 75-percent Federal financial participation currently available to your State for MMIS operations will be continued. This rate will remain in effect until the results of your next scheduled SPR are evaluated. The Chicago RO will notify you before undertaking that review.

I am pleased that your State's MMIS met the conditions for reapproval. However, I want to call to your attention those facts for which Illinois received a less than minimally satisfactory score of 70 percent. They are:

> Factor 13—*Timeliness of Processing Clean Practitioner Claims—Part 1*—The SPR revealed that Illinois did not pay 90 percent of clean practitioner claims within 30 days of receipt. Sixty-eight out of

eighty clean practitioner claims were not paid within that time period. *Actual Score: 0*

Factor 15—Timeliness of Processing Claims Other Than Clean Practitioner Claims—The SPR also revealed that Illinois did not satisfactorily pay other than clean practitioner claims within 30 days of receipt. Only one of the twelve claims in the sample were paid within that time period. *Actual Score: 8*

These problems are similar to those we identified in each of the past 4 consecutive years (FYs 1987 through 1990). Your State's passing the FYs 1990 and 1991 SPRs can be contributed largely to changes in our scoring methodology, rather than to corrective actions taken by your State in these areas.

I encourage you to take prompt action to resolve these timely claims processing problems. HCFA staff are ready to assist you. Please contact the Chicago RO for any assistance you need or if you have any questions.

Sincerely yours,

Christine Nye
Director
Medicaid Bureau

cc:
Regional Administrator
Chicago

State Medicaid Director

[ILLINOIS DEPARTMENT
OF PUBLIC AID LETTERHEAD]

November 27, 1991

Mr. Chester C. Stroyny, Regional Administrator
Department of Health and Human Services
Health Care Financing Administration
Region V, 105 West Adams, 15th Floor
Chicago, Illinois 60603-6201

Dear Mr. Stroyny:

This letter is in response to your letter of November 1, 1991. I am responding for Phil Bradley, Director.

You requested our corrective action plan to the "1991 Medicaid Management Information System, System Performance Review." We concur with your finding, however, we want to reiterate that failing the Timeliness Factors 13 and 15 was not due to MMIS Systems deficiencies but rather was caused by an extreme shortfall of appropriated funds.

If you have any questions please contact me at (217) 782-1136.

Sincerely,

James R. Donkin, CIA
Chief Internal Auditor

JRD:nw

cc: Charles W. Hazlett